STATE OF MONTANA
Department of Public Health and Human Services

LEVEL I SCREEN

PLEASE READ THE INSTRUCTIONS ON THE SECOND PAGE OF THIS FORM FOR DETAILS.
HISTORY & PHYSICAL AND LIST OF MEDICATIONS MUST BE INCLUDED WITH THIS FAX.
FAX NUMBER: 1-800-413-3890/443-4585 TELEPHONE NUMBER.: 1-800-219-7035/443-0320

Applicant's Name _____ SSN _____ Date of Birth _____

Diagnosis Primary _____ Physician _____

Secondary _____ Provider _____

Other _____ City _____

Is there a current H & P [ ] Yes [ ] No If no, call Foundation for instructions.

A.	**MENTAL ILLNESS**	**YES**	**NO**
1.	Does the individual have a diagnosis of serious mental illness (MI)? Diagnosis _____	[ ]	[ ]
2.	Does the individual have any indications of a mental illness? If yes, describe. _____ _____	[ ]	[ ]
3.	If the applicant has a diagnosis or indications of mental illness, does the individual have a primary diagnosis of dementia? _____	[ ]	[ ]
4.	Is the individual on antipsychotic medication? If yes, what is individual's a) current mental status; b) reason for medications; c) length of time on medications. _____ _____	[ ]	[ ]
5.	Is individual on an antidepressant? If yes, indicate a) history of depression; b) length of depression; c) current depressive status; d) whether depression is situational due to circumstances. _____ _____	[ ]	[ ]

B.	**MENTAL RETARDATION OR RELATED CONDITIONS**	**YES**	**NO**
1.	Does the individual have a diagnosis of mental retardation (MR)?	[ ]	[ ]
2.	Does the individual have a diagnosis of a related condition (cerebral palsy, autism, seizures, etc.)?	[ ]	[ ]
3.	Has the individual ever been referred to or served by an agency/institution serving persons with mental retardation or related conditions?	[ ]	[ ]
4.	Does the individual have any indications of mental retardation or a related condition?	[ ]	[ ]
5.	Does the individual have a brain injury? _____ _____	[ ]	[ ]

C. INFORMATION SOURCE

The above information has been provided by: Name _____ Date_____

Agency _____ Phone No. _____ Fax No. _____

FOR FOUNDATION USE ONLY

D. APPROVED [ ] Yes [ ] No

Referral for Level II [ ] MI [ ] MR [ ] MI/MR

MR Referral made to: _____ Date _____

MI Referral made to: _____ Date _____

Comments: _____

_____

Name: _____ Date _____

INSTRUCTIONS:

A. Serious mental illness means that the individual is diagnosed according to the criteria specified in DSM-IV as having one of the following conditions: schizophrenia, paranoia, major affective disorder, schizo affective disorder, or atypical psychosis, and does not have a primary diagnoses of dementia, including Alzheimer's disease or a related disorder, which is based on a neurological assessment;

and as a result of the diagnosed mental condition, the applicant presently suffers from significant impairment in at least two of the following functional areas:

1. ability to meet appropriate vocational or homemaker roles for the applicant's current stage of life;

2. ability to maintain community living without dependence on public support systems and monitoring;

3. ability to develop and maintain personal relationships and support systems;

4. ability to meet the normal demands of community living, including self help and self maintenance, freedom of movement, and engaging in a stage-of-life appropriate range of activities;

Indications of mental illness include delusions, hallucinations, incoherence or marked loosening of associations, flat or inappropriate affect, long-standing depressed mood, feelings of worthlessness, excessive or inappropriate guilt, recurrent suicide attempts or ideation, behavior which inflicts injury on self or others, or behavior which presents an imminent threat to self or others.

B. Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Related conditions means severe, chronic disabilities attributable to cerebral palsy, epilepsy, autism or any other condition, other than mental illness, found to be closely related to MR because the condition results in impairment of general intellectual function or adaptive behavior similar to that of persons with MR and requires treatment or services similar to those required by these persons. It is manifested before the person reaches age 22, is likely to continue indefinitely and it results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.

C. Self-explanatory.

D. Do not fill out. For Foundation use only.

E. Do not fill out. For Foundation use only.

LEVEL OF CARE INSTRUCTIONS:

A Level of Care determination is required prior to Medicaid making payment to a nursing facility or the Home and Community Based Services Program (waiver). Any individual currently eligible, applying, or who intends to apply for Medicaid needs to request a determination. **Submit the SLTC-86 (Level of Care Determination) with at least identifying information via fax or telephone to the Foundation.** The Foundation will notify the applicant, referral source and county Office of Human Services of the results.